MASSACHUSETTS LEAGUE of COMMUNITY HEALTH CENTERS

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TO: The Special Commission on the Health Care Payment System
FR: Patricia Edraos, Policy Director
RE: Public Hearing

The following is the response to the draft Principles for Health Care Payment Reform from the Massachusetts League of Community Health Centers. The Massachusetts League of Community Health Centers is the Primary Care Association for the Commonwealth. Its membership is comprised of representatives from all 52 community health centers in Massachusetts, Federally Qualified, Independent and Hospital Licensed.

Payment reform is essential but there needs to be an upfront recognition of and investment in assisting community health centers with practice redesign, HIT and organizational change. Several studies have identified a range of costs and time associated with this transition. A review of this work could inform the Massachusetts model. A phase-in period is needed to ensure centers are not at financial risk as the model changes. Some have suggested a three part payment that includes: a monthly risk-adjusted care coordination payment for work done outside the face-to-face visit (telephone, e-mail, CHW encounters, etc); a visit-based fee-for-service; and, a performance based component that recognizes quality and efficiency.

It is important that all payers participate, and that uniform quality and efficiency standards that include risk adjustment for the population served are implemented. These need to include not only adjustments for age/gender/severity, but also social factors affecting patient compliance, particularly as they have an impact on health equity. Administrative simplification is critical and should address standardization of billing, payment and other processes. Public coverage programs should have a minimum enrollment of one year to reduce the administrative costs of individuals coming on and off of eligibility requirements.

Payment reform needs to have some focus on those individuals with high cost, high intensity chronic illnesses to identify a baseline of savings. For example, asthmatics with high inpatient and ER use could be studied to determine whether changes in how care is delivered has an impact on more acute care utilization and what savings are realized.

There should be a mechanism for rewarding public health and prevention activities. For example, a community health center that establishes a farmer's market in a neighborhood with high rates of obesity, or another that implements a violence prevention program for at-risk adolescents, should be recognized for their efforts to make significant healthy changes in their communities